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THE UNIVERSITY OF ALBERTA

THE R/A PROGRAM: EVALUATION OF ATTITUDES

BY

LISE J. BOUCHER

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE

OF MASTER OF SCIENCE

IN FAMILY STUDIES

FACULTY OF HOME ECONOMICS

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FALL, 1987

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THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled THE R/A PROGRAM: EVALUATION OF ATTITUDES submitted by LISE J. BOUCHER in partial fulfillment of the requirements for the degree of MASTER OF SCIENCE.

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Date: September 18, 1987

ABSTRACT

This program evaluation determined if the output of the reassessment (R/A) program, that is the activities performed by the assessment nurses from Central Placement Office (CPO) had any secondary or long-term impacts on attitudes held by nursing home residents concerning involuntary relocation. The R/A program implemented in nursing homes located in District No. 24 consists of ongoing assessments of nursing home residents by the CPO nurses. The main outcome of this program is the identification of the level of care required by nursing home residents. Consequently, relocation to a higher or lower level of care may be suggested.

The central hypothesis for this study predicted a difference in attitudes toward involuntary relocation between a group of nursing home residents who were recipients of the R/A program and a comparison group of nursing home residents who were not part of the R/A program. A questionnaire was developed to measure the direction of the respondents' attitudes. Statistical analysis of the data comparing mean scores of both groups revealed no significant differences in attitudes between the experimental and the comparison group.

Nursing home and respondents' characteristics were also selected as variables, and it was hypothesized that

these would be related to attitudes toward involuntary relocation. Age was the only variable which reached statistical significance. It was found to be inversely related to positive attitudes held by institutionalized elderly concerning involuntary relocation.

Additionally, a Chi-square test showed that a significantly larger proportion of institutionalized elderly in the experimental group than in the comparison group would agree to relocate if the suggestion was made by a member of their family.

The results of this evaluative research apply to a number of stakeholders: politicians and policy-makers, program directors and professionals who are involved in program implementation, as well as evaluators. Thus, the knowledge gained from this evaluative research will be utilized more for decision making than actual theory building.

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Chapter One

Introduction

Program evaluation as the final step of the systematic process of program development is a dimension which is often overlooked, especially where human service programs are concerned (Attkisson & Broskowski, 1978). This deficiency is distressing when the evaluation component is missing from programs developed to deal with a segment of the population which is particularly vulnerable, for example, the institutionalized elderly. The insufficient attention given to program evaluation should disturb professionals. This situation should be seen by them as a personal challenge to turn to program evaluation to determine how their professional activities, often dictated by governmental policies or bureaucratic decisions, influence the clientele they serve. The present study is in response to the stimulating invitation to evaluate human service programs.

This evaluation is also particularly important from a family studies perspective as it involves a program which focuses on aging family members. The contemporary family is still the main provider of social and psychological support for its aging members (Shanas, 1979). However,

social changes have altered the traditional roles of the family. The extended family of yesterday cared for its elderly members. But today, the modern family shares this role with many professionals who lend assistance in the functional care of the aged. Thus, to evaluate a human service program designed for institutionalized elderly offers a challenge for professionals and an opportunity for them to discover serendipitous impacts the program may have had on the lives of aging families who have institutionalized members.

Problem Statement

Before describing the program under scrutiny, an introduction to the problem that this research addresses is appropriate. This program evaluation attempts to determine if the output of the reassessment (R/A) program, that is the activities performed by the assessment nurses from the Central Placement Office (CPO), has had any secondary or long-term impacts on attitudes concerning involuntary relocation for the R/A program recipients. More specifically, this study answers the following question:

> What is the difference in attitudes toward involuntary relocation between nursing home residents who are recipients of the R/A program, that is, residing within the geographical boundaries of District No. 24 and nursing home residents who are not part of the R/A program, that is, residing outside of District No. 24?

Although this question is the central focus of this study,

two additional questions are of interest in order to discover additional information about attitudes regarding involuntary relocation of institutionalized elderly.

> How are nursing home residents' attitudes regarding involuntary relocation related to characteristics of different nursing homes, such as the availability of the auxiliary hospital level of care within the facility, the nursing home location, and/or its ownership?
>
> What is the relationship between nursing home residents' attitudes about involuntary relocation, and respondent characteristics, for example gender, age, ethnic and religious identification, marital status, number of moves since age 40 and before being institutionalized, length of stay in a nursing home, and self-report of emotional support?

These additional questions are exploratory in nature; the variables considered have been selected with predictions that new information about factors which may influence attitudes held by long-term care residents regarding involuntary relocation, is discovered.

Setting

Having introduced the questions under investigation, a brief discussion relating the antecedents of the R/A program is in order. The first Board of Directors of the Edmonton and Rural Auxiliary Hospital and Nursing Home District No. 24 was appointed in 1961. In 1971, CPO started its operation under the executive and administrative direction of this board. CPO is an agency mandated by the Alberta Government (Nursing Homes Act, 1985)

to monitor admissions of individuals into long-term care facilities within the geographical boundaries of District No. 24 (see Appendix A).

Assessment nurses, as members of the assessment committee working for the CPO are responsible for assessing applicants and deciding on the level of care required by those who apply. Assessments are carried out in hospitals or in the applicant's home. Before the R/A program, some reassessments were performed in long-term care institutions when requested by the resident, his/her family, by the resident's medical doctor, or by the institution itself. Usually these requests meant relocating a resident to an institution of choice, or a transfer to a higher level of care, that is, a move from a nursing home to an auxiliary hospital. In addition, some requests were made to reassess a resident for a lower level of care. Such a request meant the discharge of a resident from a long-term care facility to a lodge or some other types of accommodation. However, because the trend has been to institutionalize (Schwenger & Gross, 1980), this kind of transfer was seldom requested.

It should be noted that the types of relocation discussed above may have been perceived by the institutionalized elderly as being either voluntary or involuntary, depending on whether the resident agreed or disagreed with the suggestion made. But within that context, the need for more or less care was suggested first

by someone close to the institutionalized elderly or at least by someone who was usually well known to him/her. Under those circumstances the assessment nurse simply confirmed the required level of care.

With the R/A program implemented in September of 1983, reassessments are no longer performed only upon request, but are mandatory for all nursing home residents. Initially, the assessment nurses from CPO reassessed all individuals already residing in nursing homes. Now, the R/A program is being carried out on an ongoing basis. This implies that a first reassessment is done two to four weeks after an individual has been admitted to a long-term care facility. The resident is also reassessed three months later and following, yearly reassessments are done. As physical and/or mental improvement or deterioration is plausible, continuous objective assessments of bio-psycho-social needs of institutionalized elderly are legitimate. It should be noted that eligibility for nursing home or auxiliary hospital levels of care is in accordance with criteria defined by the Nursing Homes Act (1970) and the Hospitals Act (1980), as well as the definitions of levels of care formulated on the assessment and admission form (see Appendix B). More recent legislative documents are now in use: The Hospitals Act consolidated in October of 1985 and The Nursing Homes Act assented to in June 1985. These standards are the basis

for making decisions when individuals are assessed prior to admission to a long-term care institution; these also apply to subsequent assessments as scheduled by the R/A program.

The R/A program's explicit outcome is the identification of individuals whose physical or mental condition has changed since admission. The logical but unspecified outcome of this undertaking is relocation of residents. For instance, when deterioration has taken place, movement to a higher level of care is indicated. In the event that improvement is noted, a move to a lower level of care is suggested, that is, deinstitutionalization is proposed to nursing home residents who no longer require that level of care. In other words, relocation is recommended by the assessment nurses from CPO, to those individuals who are identified as requiring a different level of care from the one provided by the facility in which they live.

This situation is different than the aforementioned circumstances when relocation was the result of either a resident's request, a family member's suggestion, a doctor's order or the institution's wish. In the R/A program context, the suggestion comes from someone who is outside the resident's personal system, his family system, and outside the institutional system where the individual resides. Thus, it should be no surprise that this type of relocation which is studied in this research is experienced by the residents as one which is involuntary. Family

members, doctors, and institutional staff members may also share this view.

Assumptions

At this point, it is appropriate to examine some assumptions which could characterize this process or period of change brought on by modifications to the existing assessment and placement procedures. First, it is assumed that prevailing attitudes with regard to involuntary relocation will be marked by antagonism. Resistance could be thought of as the initial reaction on the part of residents living in extended care facilities, and their families, when an assessment nurse from CPO indicates a need for relocation. "Institutionalization represents a last resort in providing for an aged family member" (Smith & Bengston, 1979, p. 438) and this is "often at great emotional cost to the various family members" (Mindel, 1979, p. 462). So if relocation is recommended after institutionalization has taken place, perceptions of a similar traumatic experience may be envisioned regardless of the level of care suggested. Therefore, an assumption of this study is that the older person and the family members involved, will retaliate against a move to a different facility or to the suggestion of a discharge from a long-term care institution.

Second, as noted in a context of discharging patients

from a psychiatric ward, "the bias of the review panel was toward discharge, whereas hospital review, when it occurs, tends to be biased toward the retention of patient" (Crane, Zonana & Wizner, 1977, p. 832). Corresponding biases can be expected when one considers the long-term care field. On the one hand, personnel working in long-term care facilities would be inclined to keep their residents; on the other hand, assessment nurses would favor movement to a higher or lower level of care when objective assessments dictate it. Thus, as these two groups may hold such divergent positions with respect to involuntary relocation a certain state of opposition may be produced, in which the nursing home resident may be caught in the middle.

Third, one can postulate that the R/A program challenges the medical model which still prevails in our health care system. It undoubtedly purports that assessing a person's level of care or discharging someone from a long-term care institution should be a function reserved for physicians.

All in all, these assumptions, supported by earlier gerontological studies (Smith & Bengston, 1979; Mindel, 1979; Crane, Zonana & Wizner, 1977), point to specific reactions which can be demonstrated by different groups when they are confronted by a new program such as the R/A program.

Rationale

The purpose of this study is to research some of the secondary impacts or long-term effects associated with the R/A program. The program has now been established for over three years.

Because the eventual outcome of the R/A program for its recipients is relocation, this evaluation can best be undertaken by examining nursing home residents' attitudes toward involuntary relocation. As Lefrancois (1979) states: "attitudes are subtle, pervasive and powerful predispositions to think, act, and feel in certain ways" (p. 162). It follows that reactions to involuntary relocation, for instance, could be inferred from opinions held by institutionalized elderly about long-term care, and their reported willingness to relocate. In other words, the respondent's thoughts and intentions are the attitudinal components (Sudman & Bradburn, 1982) which are regarded as having a relative influence on his/her reaction toward involuntary relocation. Attitudes are also relevant measures which can explain differences among individuals or groups. Thus, they are appropriate means to evaluate social change (Henerson et al., 1978), or program impacts.

Therefore, to focus this research on evaluation of attitudes may shed some light on the complex set of reactions which one might expect as the result of the R/A program activities. Because attitudes are manifested in

many ways, this study may also yield some valuable information about social change and program impacts for program recipients.

Significance of Study

Having established the rationale for this study, it is legitimate to examine its potential contributions. From a practical standpoint, to examine program impacts furthers awareness of program effects. This research uncovers the veritable impacts of the R/A program regarding residents' attitudes about involuntary relocation. Also new knowledge is acquired as this study clarifies if nursing home and/or residents' characteristics do influence attitudes about involuntary relocation held by the R/A program recipients. This knowledge is practical because it can be applied at all levels of programming when the target population is institutionalized elderly.

In addition to the contributions considered, public accountability must be mentioned (Freeman & Bernstein, 1975). The impact of social institutions on aging family members must be explored. When community agencies, such as CPO, implement new programs, evaluation should be used to analyze the program impacts on the program recipients. This evaluation of the R/A program does this.

From a theoretical perspective, this study is an example of the manner in which program evaluation and

systems theory can be integrated in an applied context. The use of systems theory clearly demonstrates the interdependency of all the different components of a social program. Besides, this research increases the existing knowledge concerning attitudinal differences as applied to residents living in long-term care centers.

The above list shows the practical as well as the theoretical worth of this evaluative research. The prospective consumers of this evaluative research are many: from institutionalized elderly and all concerned with the aged, to those involved in different steps of programming and policy making. This present research may serve as a model for those interested in examining program impacts. But more so, this study should challenge other professionals involved in helping and assisting families, to objectively and critically investigate their professional activities, in order to determine the actual impacts they may have on those they serve.

Limitations

Given the relatively small number of nursing home residents within the geographical boundaries of District No. 24, the total population for this study was less than 2500 individuals. Due to either poor physical condition and/or mental deterioration, not all residents could be included in this study. Therefore the findings are

generalizable to interviewable institutionalized elderly who are similar to those in the study sample.

Also, the fact that this evaluative research was ex post facto did not permit experimental control. The independent variable could not be manipulated and random assignment of subjects to an experimental treatment was not possible. But because program evaluation occurs in real-life situations, it remains a valuable research area.

Delimitations

A few limits must be defined in order to clarify the boundaries of this study. First, only nursing home residents have been considered for the sample. Second, only English speaking individuals were included in this survey to avoid interpretor use. Third, because of financial and time constraints, attitudes about involuntary relocation held by family members, workers employed in nursing homes and by assessment nurses from CPO were not explored. Lastly, this research focuses on the cognitive and action components of attitudes and not on the affective component.

Chapter Two

Conceptual Framework

As no conceptual framework nor theory has been specifically selected to facilitate or stimulate evaluative research, program developers, program directors and program evaluators have often adopted the goal-attainment model and the system model (Schulberg & Baker, 1968) to assist them in the study of evaluation. As the long-term care field can easily be examined from the viewpoint of systems theory, this theoretical approach is very appropriate to provide the framework for this study. Moreover, as this program is implemented by a community agency which is part of the larger health care system, systems theory can be seen as the best starting point for researching secondary impacts of the R/A program. But before describing how this framework fits this specific context, a brief explanation of relevant general systems components with their interrelationships is appropriate. This provides the reader with an overview of the systems approach.

Introduction to General Systems Theory

General systems theory was first introduced by Bertalanffy (1962) in the late thirties. It is a

conceptual approach which permits the study of complex organizations as unified wholes, that is, "complexes of elements standing in interaction" (Bertalanffy, 1956, p. 2). So, from a systems perspective, our society can be viewed as a number of complex structures interacting with one another. In turn, these structures are formed by interrelated elements which constitute the whole. This statement can be juxtaposed to Hall and Fagen's (1956) definition which states that: "a system is a set of objects together with relationships between the objects and between their attributes" (p. 18).

Two points should be specified here. As cited above, a system is composed of interacting parts which form a united whole. Successively, these parts can also be categorized as subordinate systems, themselves consisting of integrated units, thereby constituting essential systems called subsystems. Together, the above statements convey the central concepts proposed by systems theory.

Environment, Input and Output

As systems do not exist in a void but within a societal context, the notion of environment must be brought forth. "The environment is the set of all objects, a change in whose attributes affect the system, and also those objects whose attributes are changed by the behavior of the system" (Hall & Fagen, 1956, p. 20). The system's

environment can thus be conceived as the physical objects, the people, the psychosocial aspects of society, and the aggregate of cultural, political and economical conditions and circumstances which influence the system. Furthermore, the system's environment can also be said to include the specific factors when these are alternately influenced by the system. External influences affecting the system have been termed the input, whereas the effects of the system on outside elements have been called the output (Hall & Fagen, 1956).

A distinction between closed and open system must be established. Closed systems "are considered to be isolated from their environment" (Bertalanffy, 1956, p. 3). Contrarily, open systems are characterized by an exchange of "materials, energies, or information with their environment" (Hall & Fagen, 1956, p. 23). Evidently, living systems, biological or social, are open systems as they are subjected to outside influences. These systems are said to interface with their environment, a process of exchanges between the internal and external environment.

Adaptation and Feedback

Since societal environment is characterized by a tendency to continuous change, a social system must adapt in order to survive (Hall & Fagen, 1956). In other words, events or changes which occur outside the system but within

its environment must be integrated in some ways so as to promote the system's adaptation and survival. Also, the system's activities affect the environment. This output, as it affects the system's environment, needs to be fed back to the system as input in the form of information (Bertalanffy, 1956). Through this feedback mechanism the system is compelled to process new data, thereby stimulated to regulate its activities. In systems theory, negative feedback implies "homeostatic maintenance of a characteristic state" (Bertalanffy, 1956, p. 7), and positive feedback means "equifinality, the tendency towards a characteristic final state from different initial states" (p. 7). Negative feedback promotes the maintenance of the status quo, and positive feedback encourages adaptation and change. For instance, feedback as the information resulting from evaluating social programs can directly influence the system to either maintain its present state or to alter it.

The preceding information about systems theory helps the reader understand how this theoretical framework fits this evaluative research. The application of this approach to the present study further clarifies this theory and some of its components.

Systems Theory and the R/A Program

In "systems theory, public policy is the response of

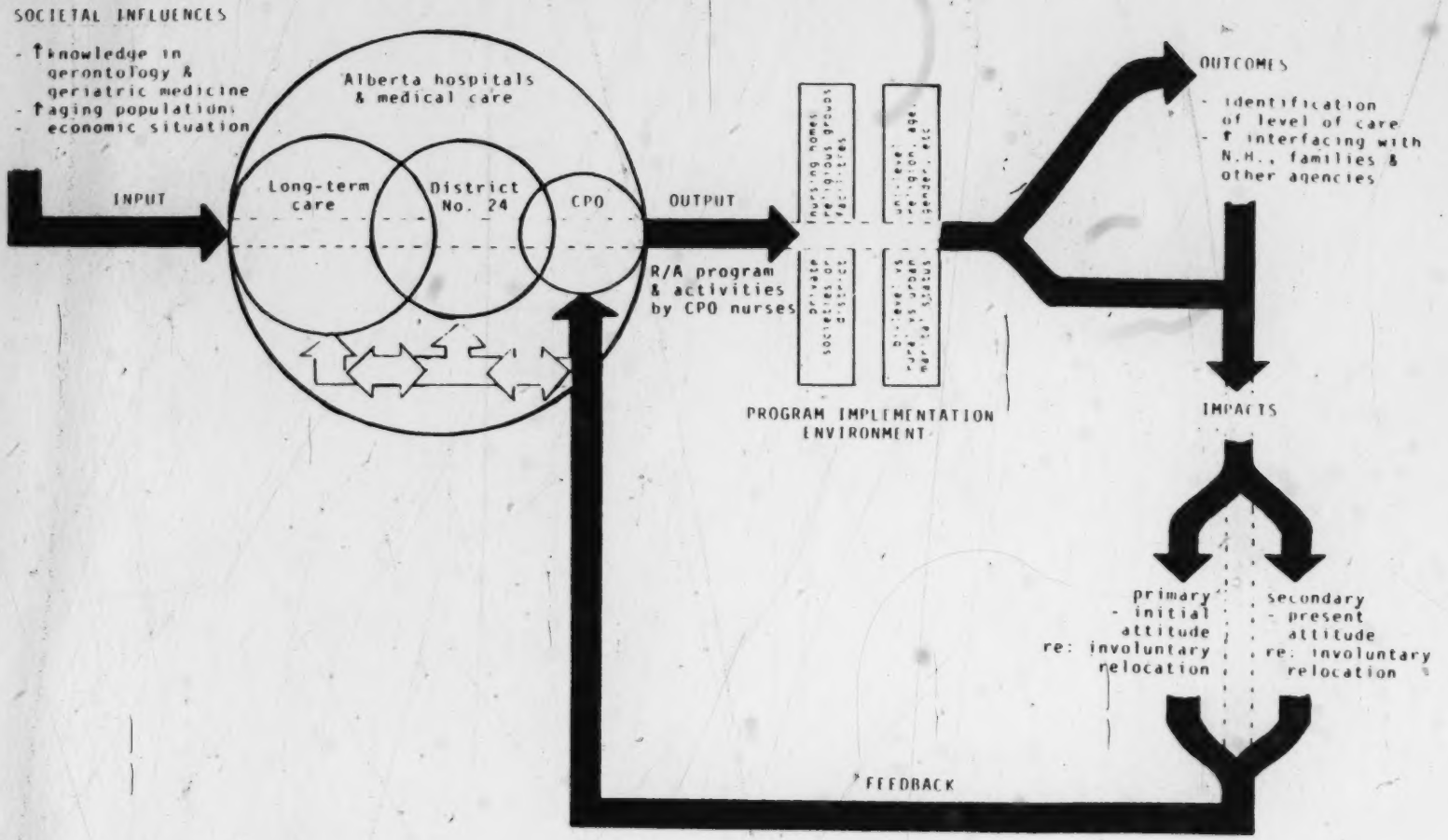

Figure 1. General systems theory: An approach to the R/A program

the political system to demands arising from its environment" (Anderson, Brady & Bullock, 1978, p. 47). It is relevant here to expound on some of the societal factors which may have disposed policy-makers toward the development of the R/A program. Refer to Figure 1 for a graphic representation delineating the relevant systems and subsystems necessary to understand the context of this evaluative research. The figure illustrates how each subsystem interfaces with each other and how their interacting parts form a united whole.

First, present demographic data and projected figures reveal a sharp and continuous increase of Canadian people age 65 and over. The latest census of Canada taken in 1981 shows that the Canadian population age 65 and over was slightly over 2 million (Census and Household Statistics of Canada, 1984); the projected figures for the year 2001 and 2031 are respectively close to 4 million and slightly over 7 million (George & Perreault, 1985). In 1901, less than 2% of the Albertans were 65 years of age and over (Stone & Fletcher, 1981, Chart #31); in 1981, the same population represented over 7% of the total Alberta population (Statistics Canada, 1981). And in the year 2000, that Alberta population is expected to be over 277 thousand, which will represent over 11% of the total provincial population (George & Perreault, 1985). These figures definitely show a steady increase in numbers of elderly people.

Second, it is to be noted that in 1981 the number of Albertans age 65 and over who were institutionalized in nursing homes, chronic care and old age homes represented over 9% of that population, or slightly over 15 thousand. If the institutionalization trend remains the same, institutionalized elderly in the province of Alberta will reach nearly 25 thousand in the year 2000. This situation combined with an aging population will be reflected in cost increases in long-term care. For instance, public expenditures for institutionalized elderly are escalating. In 1981, the Alberta government spent $57,822,292.00 on financial assistance for nursing home care (Public Accounts, 1980-81). For the provision of financial assistance for the same level of care, the expenditure for 1985-86 equals $111,048,539.00, an increase of $53,226,247.00 or 92% (Public Accounts, 1985-86). Thus, the proportion of medical care dollars spent for institutionalized care for the elderly is substantial, and with time, will inevitably increase.

Third, though gerontological research is in its infancy (Marshall, 1980), and the rate of specialization of medical doctors in the area of geriatric medicine is still low (Skelton, 1986), there is an increasing knowledge base in the fields of gerontology and geriatric medicine. This new knowledge has led to the development of other new programs like home-care, day-care, meals-on-wheels, etc.

Thus, institutionalization is no longer seen as the only solution for the frail elderly as a variety of services are now available.

All in all, these changes within the system's environment have created new demands: for example, to insure adequate assistance to an increasing number of elderly while restraining government spending. In systems theory, these claims on social systems are called the input. The R/A program can be seen as the response of the long-term care subsystem to conditions and events which have occurred in its environment. By objectively identifying the individuals whose physical/mental condition has changed since admission, the lowest level of care can be suggested thus stretching allocated social and economic resources.

CPO: A Social System

The community agency in charge of implementing the R/A program is the Central Placement Office. CPO can be described as a subsystem of Edmonton and Rural Auxiliary Hospital and Nursing Home District No. 24, which in turn is a subsystem of the provincial long-term care system. These three subsystems are components of a larger system, namely the Alberta hospitals and medical care ministry.

However, CPO also constitutes a system in itself: it is composed of interrelated components existing in a

particular environment. First, the individual components of CPO are the administrator, the assessment nurses, and the clerical staff members. In addition, nonhuman resources such as policies, procedures, equipment and assessment forms are also elements of this system.

Second, the relationship among the system's components is a complex communication system resulting from the workers performing their respective duties and their use of nonhuman resources. In other words, while at work, employees are required to relate to one another in order to achieve organizational objectives.

Third, is the environment. The societal environment includes social changes affecting CPO, a subsystem of the health care system. The contextual situation or where the R/A program is implemented can also be considered here. It varies in some characteristics according to different aspects of the situation. In other words, the R/A program activities take place in different nursing homes or in specific contexts. It can happen in a governmental nursing home, or in one which is owned by a society or a religious order, or in a privately owned nursing home. The institution can be located in a large urban setting or in a smaller center. Those nursing homes owned by a society or a religious order are affiliated with a specific church, whereas the others are non-denominational. Reassessments can also take place in a facility which provides only for

nursing home level of care, or they can occur in a bi-level facility set up to accommodate both nursing home residents as well as auxiliary hospital patients. All these factors as well as respondents' characteristics which are part of the implementation environment of the R/A program may influence its impacts. A scrutiny of the implementation environment of the R/A program was included to provide information regarding its effects on the program's recipients.

Impacts versus Output

When evaluation research is conceptualized from a systems perspective, a major distinction must be pointed between impacts and output. In the realm of organizational or political activity, output is regarded as the "measure of government activity" (Dye, 1975, p. 328). In this study, output is the actual reassessments carried out by the assessment nurses from CPO. In contrast, impacts are referred to as the "effects on the real-world condition" (p. 327). Therefore, impacts are viewed as attitudes held by program recipients in regards to involuntary relocation. This distinction between impacts and output is noteworthy as it is the impacts that this evaluative research assesses.

Moreover, impacts can be subdivided in two parts: primary and secondary impacts. Primary impacts "refer to immediate changes resulting from program activity" (Cook &

Scioli, 1975, p. 101), and secondary impacts relate to "long-term consequences" (p. 102). In this case, primary impacts were not measured, so data regarding initial reactions to involuntary relocation are not available. However, evaluation of secondary impacts, gives information about the long-term effects of the R/A program.

Although program outcome is not the subject under consideration of this research, it is nonetheless an integral element of this conceptual structure. Outcomes are directly derived from the output or the program activities, as these are specified by the program objectives. In this situation, the main program objective is to assess all long-term care residents in order to establish on a continual basis, their required level of care. The program activities are the actual assessments of institutionalized elderly. The principal outcome is the identification of the level of care required by all long-term care residents. In addition, this ongoing procedure produces increased interfacing with institutionalized elderly and also with their families, their doctors, workers in long-term care institutions, as well as other professionals from different community agencies.

Other outcomes could be specified. The ones mentioned are adequate to illustrate the wide ranging ramifications generated by a single objective of the R/A program.

CPO: An Open System

Within the systems framework, CPO can be said to be an open system. As stated earlier, much interfacing between CPO and the program implementation environment takes place on a continuous basis. Also, at the administrative level, some exchanges occur with the administrators of District No. 24 and administrators of other community agencies. Therefore, there is a continuous flow of information in and out of the system.

The fact that information moves freely in and out of CPO brings to mind the concept of feedback. This mechanism serves a twofold function: stability and adaptation. Through this process, program outcomes and program impacts are made known to the program administrator (Schulberg & Baker, 1968). When new programs are developed, like the R/A program, it is to be expected that their implementation will alter the system's environment. Program activities create changes. If these changes are minimal, the system, through negative feedback, remains stable. When the modifications introduced have extensive effects, the information fed back to the system requires attention. With positive feedback, the system's equilibrium is threatened, and if it is to survive, it must adapt.

From a system's perspective, this evaluative research can be conceived as part of the feedback mechanism. The data obtained from evaluating the R/A program's secondary

impacts can be transmitted back to the system. This information will need to be considered as it will challenge the system to either maintain its present state, or make the proper modifications and adapt.

Chapter Three

Literature Review

One section of this chapter presents a review of the literature on evaluation. Relevant aspects of this subject matter such as pertinent definitions, various types and purposes of evaluation, as well as considerations regarding evaluation designs are discussed. Because this research evaluates program impacts within the context of involuntary relocation of long-term care residents, the literature pertinent to involuntary relocation is discussed in a second section.

Evaluation

Introduction. Before introducing the basic concepts reviewed in the literature on program evaluation, a few introductory comments are in order. Subjective judgments regarding the merit of a particular program have always been made. But objective assessments of program goals, objectives, activities, impacts, effects, costs, and so forth began only after WW II (Franklin & Thrasher, 1976). In fact, the prevalence of evaluation as a systematic process emerged during the sixties and seventies (Edwards & Newman, 1982). This is especially true for evaluation of

social programs. Initially, the only standard of success of such programs was that they were organized for the purpose of doing good (Gurel, 1983).

Though the rate of occurrence is still low (Gurel, 1983; Suchman, 1967), evaluation is now considered an important and necessary step of program development (Caro, 1969; Gurel, 1983). However, program evaluation as an area of scientific inquiry is still underused. Consequently, the possible scope of its influence is kept to a minimum.

Another observation which helps in understanding the present standing of program evaluation is that evaluation is still lacking a common accepted definition (Freeman & Bernstein, 1975; Patton, 1982; Rutman & Mowbray, 1983; Suchman, 1967). When perusing the literature on program evaluation, one can therefore expect that terms such as program evaluation, evaluative research, and policy analysis are used interchangeably by writers. However, the idea of systematic assessment remains constant and underlies all the different terms employed (Caro, 1969; Patton, 1981; Rutman & Mowbray, 1983; Tripodi et al., 1971).

Lastly, it should be noted that there are usually numerous groups that could be affected by a particular program evaluation. It is therefore essential to identify those interested in the evaluation, and the ones who may be influenced by it. These groups have been called

stakeholders (Edwards & Newman, 1982; Posavac & Carey, 1985). Stakeholders usually include the governing body or legislative authority, the program director or manager, the practitioners or workers charged with implementing the program activities, and the consumers or program recipients. Altogether, these different groups of people have a vested interest in the program, and consequently in its evaluation.

Definitions. As mentioned earlier, there is lack of consensus regarding the meaning of some of the terms used in evaluative research. Nevertheless, the discussion of a few definitions will acquaint the reader with the terminology utilized in this research.

Program evaluation is defined as a process by which program results are measured against established objectives, standards, impacts, or specified goals (Angrist, 1975; Soumelis, 1977; Weilenmann, 1980). Thus, when a program is evaluated, a comparison is made between what a program sets out to do, and what has actually been accomplished. Evaluation also implies the act of showing the relative value and worth of a program (Franklin & Thrasher, 1976). This definition conveys the inclusion of subjective judgments as part of its meaning.

Evaluative research implies the use of the scientific methods (Franklin & Thrasher, 1976; Hoole, 1978; Rossi & Freeman, 1982; Suchman, 1967). In this case, evaluations

are performed according to an empirical methodology. Therefore, when the scientific approach is applied to evaluate a program or a policy, the evaluation can be described as evaluative research. It should be added that the literature calls attention to the difference between evaluative and scientific research. Scientific research and evaluative research do not differ in terms of methodology and rigor when the principles of the scientific method are respected. The difference lies in the intent of the researcher (Franklin & Thrasher, 1976). The main objective of scientific research is the discovery of knowledge (Kerlinger, 1986; Kidder, 1981), that is to describe, explore, explain, predict, and so forth. However, in evaluative research, the main goal is to gather information for sound decision-making, for finding answers to practical questions (Kidder, 1981; Patton, 1982; Suchman, 1967). In other words, the focus of scientific research is knowledge itself, whereas evaluative research concentrates on solving practical problems.

Policy analysis is defined as the process of judging the extent to which goals or objectives set by politicians and policy-makers are being met (Anderson et al., 1978; Brewer & deLeon, 1983; Carley, 1980; Jones, 1970). Thus, bureaucrats are invited to scrutinize policy issues through the use of the scientific approach. By this process, policy-makers learn factual information which is required

to make objective decisions about existing policies.

The above definitions are so closely linked that it is evident why one definition is often substituted for another. In a way, these definitions merely present different perspectives from which evaluative research can be examined. Consequently, whenever the principles of the scientific method are respected, program evaluation and policy analysis can both be considered as evaluative research.

Types of evaluation. A classic categorization of evaluation as defined by Scriven (1981), is formative versus summative evaluation. Formative evaluations are designed to provide feedback throughout the different stages of programming, so decision-makers and program managers can make the required revisions as the program evolves. Summative evaluations, undertaken after a program has been implemented, are intended to gather information about the program, in order to assist decision-makers or program directors in judging if a program should be continued or terminated. However, according to Mark and Cook (1984), formative and summative categories are not general enough to cover all types of evaluations. Furthermore, they indicate that such a classification may lead to misinterpretation as results from summative evaluations are used in a formative way, and findings from formative evaluations are applied in a summative way. The

distinction between formative and summative evaluation is also criticized for being more suitable for evaluating programs in the field of education rather than social programs (Franklin & Thrasher, 1976). These authors and others (Freeman & Bernstein, 1975; Patton, 1981; Weilenmann, 1980), suggest a combination of formative and summative evaluation as the ideal way of evaluating social programs. Unfortunately, such comprehensive evaluations are rarely carried out, as limitations such as time, money, personnel, may preclude such studies.

Evaluations can also be classified according to the program component which is the focus of the research. One type of evaluation concentrating on the implementation phase is called process evaluation (Franklin & Thrasher, 1976; Freeman & Bernstein, 1975; Morell, 1979; Posavac & Carey, 1985; Stufflebeam, 1983; Suchman, 1967). Process evaluations focus on the course of action or the methods of implementing the program. Such evaluations yield information about the program dynamics or what goes on inside the program. In other words, process evaluations seek to ascertain if program activities were implemented according to the plan outlined in the developmental phase.

Impact, outcome and product evaluations are types of evaluations which concentrate on what happens after a program has been implemented (Franklin & Thrasher, 1976; Stufflebeam, 1983). These evaluations attempt to measure

the effects program activities or interventions have had on the recipients. This type of evaluation may also assess the degree of change a program may have effected, as compared to specified goals and objectives (Cain & Hollister, 1972; Freeman & Bernstein, 1975; Rossi & Freeman, 1982; Maynard-Moody & McClintock, 1981; Ziegenfuss & Lasky, 1980). When the researcher's main target is assessing actual effects of program activities without the knowledge of what the program attempts to achieve or its goals and objectives, the evaluation is said to be goal-free (Scriven, 1972, 1981).

Lastly, evaluation of evaluation, or metaevaluation is another type of evaluation (Posavac & Carey, 1985). Though metaevaluation is a rare practice, it is an important mechanism used by evaluators to control the quality of evaluative research. Conducting a metaevaluation provides accountability for evaluators while increasing the knowledge base of evaluative research.

The above typology has covered the classical types of evaluation which are relevant to social programs. Other types of evaluation such as efficiency, feasibility, and cost-effectiveness studies are also mentioned in the literature. However, for the purposes of this review, only the ones relevant for this study have been described.

This program evaluation can be categorized as a formative evaluation. Actual impacts are detected, and

some recommendations are made. These recommendations, conceived as feedback will be passed on to the program administrator. This evaluative research can also be classified as an impact evaluation as it examines the possible effects, generated by the R/A program activities or the reassessment procedures carried on by the CPO nurses, on the program recipients.

Purposes of evaluation. What are the intended purposes of evaluative research? From the aforementioned classification, intended purposes can be specified. First, there is a need to identify program variables which will produce the desirable outcome or impacts (Angrist, 1975; Weiss, 1984). Decision-makers and programmers should predict that a particular output linked with a specific implementation environment will influence a program in a particular way. Thus, knowledge of variables which are known to effect change in a specified direction will help programmers develop effective programs (Patton, 1982).

Second, innovative programs often generate a state of uncertainty as individuals are often skeptical when faced with social changes. Evaluative research can serve the useful purpose of establishing objective measures of the impacts produced by social programs (Cronbach, 1982). Therefore, when program developers, managers, implementors or recipients express dissatisfaction and uncertainty in regards to certain program consequences (Suchman, 1967;

Tripodi et al., 1971), program evaluation can be used to provide objective data which helps to dissipate such situational uncertainty and dissatisfaction (Austin et al., 1982). In other words, evaluative research permits the disclosure of measurable impacts of social programs as well as the exposure of distorted perception of facts and conditions associated with such programs. Once exposed, the situation can be dealt with in an objective manner.

Along the same line of thought, program evaluation can help eliminate beliefs and myths held by various stakeholder groups (Cronbach, 1982; Freeman & Bernstein, 1975). Instead of assuming program worth and utility because of a popular but unfounded notion, factual information and basic value of program interventions can be demonstrated. Altogether, evaluative research attempts to describe program consequences in an accurate manner; it promotes clarity and objectivity.

Third, evaluative research attempts to increase the body of knowledge in the field of social sciences (Rutman, 1984). Evaluation offers the possibility of increasing the existing knowledge regarding human behavior and our social world. Solutions to practical problems may also be established. Evaluative research challenges social scientists to integrate their findings into a broader scientific context thereby developing models and theories which will seek to explain how planned changes occur (Angrist, 1975; Caro, 1969).

The goals of this evaluative research are directly derived from the evaluation purposes stated above. First, to examine the program implementation environment gives some indication as to its influence on the R/A program impacts. In other words, it clarifies if nursing home characteristics and respondents' characteristics are variables which have an effect on attitudes held by nursing home residents concerning involuntary relocation. Second, the factual information obtained by assessing the direction of attitudes, held by nursing home residents about involuntary relocation, helps to specify their willingness to relocate. As these findings are objective, some uncertainties associated with the secondary impacts of the R/A program can be eliminated. Third, statistical analysis of the data collected for this project provides some information which can be used to improve social programs for institutionalized elderly. It also leads to a broader knowledge base about involuntary relocation.

Evaluation designs. As stated earlier, to qualify as research, evaluative studies must be undertaken with the rigor of the scientific approach (Caro, 1969; Freeman & Bernstein, 1975; Hoole, 1978; Rutman & Mowbray, 1983). Though the scientific process is supported by evaluators, no single design or model is suitable for every evaluation project. The best design will be the one dictated by the specific situation (Franklin & Thrasher, 1976; Rutman,

1984; Soumelis, 1977), according to the program characteristics, and time and budgetary constraints. Therefore, each program setting should suggest the appropriate approach to the evaluator. A comment should be made about the position held by Morell (1979) who disagrees with the use of the scientific method when evaluations are concerned. He argues in favor of a technological model which he has developed. He believes that as technology is grounded in the real world, evaluative research should turn to a technological model to answer questions about programs which also exist in a natural setting.

The question of who should conduct the evaluation study should also be addressed. In-house evaluators are evaluators connected with the program or the organization responsible for the program (Posavac & Carey, 1985; Suchman, 1967). External evaluators are usually consultants hired from outside the organization. The decision between having the evaluation done internally by the organization, or hiring an external evaluator is a difficult one, because both have advantages and disadvantages (Fink & Kosecoff, 1978; Posavac & Carey, 1985; Soumelis, 1977; Suchman, 1967).

In-house evaluators are usually knowledgeable about the program to be evaluated. Also as they are currently working for the organization, their presence may be less noticed. However, because they are closer to the program,

they may lack objectivity. As for external evaluators, they may stand in an unfavorable position with respect to knowing the program to be evaluated, its setting and its components. In addition, they may be perceived as intruders. But, external evaluators are also perceived as more credible evaluators with much expertise in evaluative research. They are also seen as more objective as they are not as close to the program as an in-house evaluator.

Suchman (1967) suggests that evaluation projects be carried out by both in-house and external evaluators. Fink and Kosecoff (1978) support the hiring of external evaluators, because of their objective perspective and their credibility which often promotes the acceptance of the evaluation findings. Others, like Soumelis (1977) maintain that the type of project will determine if the evaluator should be from within the organization or should be an outsider. In any case, it should be kept in mind that both types of evaluators present advantages as well as disadvantages.

For this research, the contextual situation dictated the selection of an ex post facto study; it was carefully designed to systematically examine attitudes held by institutionalized elderly in regards to involuntary relocation. To maximize the possibility of determining the actual influence of the R/A program on attitudes about involuntary relocation, a comparison group was introduced.

Also this researcher can be seen as one who possessed the advantages of both the internal and external evaluators: well acquainted with the program for being a former CPO nurse, and objective about it because no longer employed there.

Summary. The relevance of reviewing the pertinent aspects of literature on evaluation lies in the fact that this review established the state of the art about this specialized field of research. To have elaborated on the definitions, the types, and the purposes of evaluation clarified the essential concepts necessary for a clear understanding of this subject. Moreover, this review has made it possible to show the logical link between the evaluation concepts presented and the essential elements of this study.

Involuntary Relocation

Introduction. As this research attempts to determine the impacts of the R/A program on attitudes held by nursing home residents regarding involuntary relocation, perusal of the literature related to involuntary or forced relocation is essential to describe the components as these relate to this subject. In order to delimit this topic, types of involuntary relocation are described. Following, involuntary relocation as it affects mortality rates of relocatees is discussed. The information gathered from the literature about the stressful aspects attributed to

involuntary relocation follows. Afterwards, interventions which are said to be helpful in attenuating deleterious effects associated with involuntary relocation are presented. Since individual characteristics may indicate the degree of personal vulnerability of prospective relocated persons, these are also examined. Next, the concept of attitudes as dealt with by researchers is addressed. A few remarks are made about the measuring instruments and the methodological designs used by researchers for examining involuntary relocation and finally, a summary is presented.

Types of involuntary relocation. Involuntary relocation has been the focus of various studies. A few researchers have examined forced relocation of older population occasioned by urban renewal projects (Brand & Smith, 1974; Eckert & Haug, 1984; Kasteler et al., 1968). Others have looked at relocation of geriatric residents from one institution to another (Aldrich, 1964; Borup et al., 1980; Bourestom & Tars, 1974; Dimon, 1979; Gutman & Herbert, 1976; Killian, 1970; Kral et al., 1968; Markus et al., 1971; Miller & Lieberman, 1965; Wells & Macdonald, 1981; Zweig & Csank, 1975). Such interinstitutional moves usually occur because older buildings no longer meet established safety standards, or institutions are closed for administrative reasons. Forced intrainstitutional relocation has also been researched (Brody et al., 1974;

Liebowitz, 1974; Patnaik et al., 1974). This type of relocation pertains to moving within the same institution, for example from one room to another, or from one floor to another.

The purpose of the above classification is merely to identify the different contexts from which involuntary relocation has been examined. Though these studies all have different environmental circumstances and conditions, their focus is the same: to explain some of the effects of forced relocation on elderly population. However, as this research focuses on a segment of the elderly population who lives in long-term care facilities, this part of the literature review is restricted to studies in which involuntary relocation is examined from an interinstitutional or intrainstitutional perspective. To set this criterion is to recognize the specificity of the long-term care milieu and the particularity of the institutionalized population.

Involuntary relocation and mortality rates. Initial inquiries investigating involuntary relocation concluded that forced relocation was positively correlated to higher mortality rates of relocated older persons. These mortality rates of relocatees were compared to either anticipated death rates or control groups of nonmovers (Aldrich, 1964; Bourestom & Tars, 1974; Killian, 1970). Though Killian's research supported the above premise, his

findings may have been influenced by an extraneous variable which could account for higher mortality rates. As he reports, when buildings were evacuated, these were demolished and burned. However, while waiting for transfer, some old people were staying in adjacent buildings. They became afraid of being burned alive. Thus, the fear of the nearby fire or the fear of being burned alive might be a rival explanation for the results. This situation may have increased the vulnerability of this group of relocated individuals, explained by a higher mortality rate, following relocation.

Employing a matched control group of nonrelocated institutionalized elderly, Bourestom and Tars (1974) reported that one group of elderly people subjected to radical environmental changes had a significantly higher mortality rate than another group of older relocated persons who underwent only moderate environmental changes. Radical environmental changes resulted in new physical surroundings and changes in personnel, patient population and routine, whereas moderate environmental changes meant only moving to a new building while residents and care workers remained the same.

Although more recent studies found no increase in mortality rates after relocation took place (Borup et al., 1979, 1980; Coffman, 1983; Dimon, 1979; Gutman & Herbert, 1976; Pablo, 1977), a greater number of researchers found

inconsistent results while studying forced relocation. For example, Kral, Grad, and Berenson (1968) found a significantly higher mortality rate for relocated males, but no increase for relocated females. While comparing two groups of older persons from two different institutions who were forced to relocate, to a control population from the same institutions, Markus et al., (1971) found a significantly higher death rate for males from the first group and for females from the second group. However, as the control group consisted of nursing home residents who lived at these two institutions and on whom quarterly death rates were calculated for a period of 15 years prior to the move, the inconsistent findings were attributed to chance and/or different admission policies over the years at these two institutions.

In addition to these inconsistent results, other surprising findings must be included. While investigating mortality rates as an effect of forced relocation, Zweig and Csank (1975) found an interesting correlation between involuntary relocation and death rates. They reported a decreased mortality rate for subjects moved from an older building to a newer facility when they compared yearly mortality rates for the three years prior to the move with death rates for the year following the move. They observed that the highest mortality rates occurred the year immediately preceding the move. This fact alone could

explain a lower rate after relocation, as it is possible that the most vulnerable residents, to the impacts of relocation, died before the move took place, thereby reducing the number of deaths post-relocation. These findings may also indicate that attitudes toward relocation or anticipation of the move are related to a higher mortality rate (Borup et al., 1980).

Involuntary relocation as stressful. Eventhough the above findings report conflicting results about forced relocation and mortality rates, a number of researchers have asserted the traumatic aspect of involuntary relocation for a geriatric population. Whether the stress is assessed by physiological measures and/or health status (Bourestom & Tars, 1974; Kral et al., 1968; Pablo, 1977), or measured by psychological testing and/or personal adjustment scales (Brody et al., 1974; Pablo, 1977; Wells & Macdonald, 1981), or evaluated by observing behavior patterns and social activities (Bourestom & Tars, 1974; Moos et al., 1984; Patnaik et al., 1974), the findings concur that relocation is a major change accompanied by much stress. Relocated persons almost constantly showed less adjustment to the institutional environment, and more dissatisfaction with their health status and life in general when compared to nonmovers, especially during the first three months after the move.

Moreover, the impacts of involuntary relocation may

even be felt by nonmovers as well (Leibowitz, 1974; Locker & Rublin, 1974; Pablo, 1977). Institutionalized elderly may become depressed as roommates or friends are relocated. Nonmovers may also become anxious as they may fear impending relocation. Though nonmovers have not been studied, the stress experienced by them should not be overlooked.

Though the general trend has been to emphasize the negative consequences attributed to forced relocation, a few studies have found this stressful life event to have some beneficial effects. Borup et al., (1980) studied the impact of forced relocation on an institutionalized older population who experienced radical environmental changes by comparing this experimental group to a control group of nonmovers. They found that forced relocation had positive effects on measures of hypochondria, as self-reported health concerns by relocated elderly decreased significantly after relocation. The researchers suggested that increased activities due to the move and the stimulating effects of a new environment may explain such results.

Mirotznik and Ruskin (1985) compared movers and nonmovers on variables such as morale, alienation, hospital satisfaction and self-concept. They found forced relocation to have a positive effect on morale and self-concept. Also, white relocated elderly as compared to

black, experienced a decrease in alienation defined as a feeling of despair and powerlessness. Only on the variable of hospital satisfaction did movers score lower after the move; but this difference disappeared after three months. The researchers attributed these positive results to the fact that this environmental change was moderate insofar as patients, staff and routines remained unchanged. The only change was in physical surroundings which resulted in a physical environment of higher quality.

Involuntary relocation and program intervention. A review of the literature points out that to moderate the intensity of the stressful effects associated with involuntary relocation, special programs have been developed. Some of these programs emphasize the need of the movers to become acquainted with their future home, either by on-site visits or slide presentation (Borup et al., 1980; Bourestom & Tars, 1974; Burnside, 1981; Gutman & Herbert, 1976; Pablo, 1977; Yawhey & Slover, 1973). Other researchers stress the importance of private or group counseling to insure emotional support for relocatees, and to disseminate accurate information about the move, thereby increasing predictability and preventing the spread of erroneous information (Borup, 1981, 1983; Locker & Rublin, 1974; Lieberman, 1974; Liebowitz, 1974; Schulz & Brenner, 1977). During these sessions, residents should also be encouraged to participate in some of the decisions and in

the planning process whenever feasible (Burnside, 1981). Follow-up programs are also advocated to minimize the stressful effects of the period after the move, while facilitating the adjustment period (Bourestom & Tars, 1974; Brody et al., 1974). The literature makes it clear that these programs should not exclusively focus on decreasing the mortality rate associated with involuntary relocation, as the findings of increased mortality rates post-relocation are not conclusive (Borup et al., 1979; Borup, 1982). Thus, these programs should be set up to reduce the negative effects experienced by movers. This idea is important and noteworthy, hence, recommendations are derived from this study.

Involuntary relocation and individual differences. The literature suggests that limitations affecting either physical and/or psychological functioning, are positively correlated to greater vulnerability of relocated persons. Physically handicapped elderly, those in poor health, psychotic individuals, and those with different mental problems, like depression and neurosis, have been found to be more vulnerable to the deleterious effects of forced relocation (Aldrich, 1964; Borup et al., 1979; Brody et al., 1974; Killian, 1970; Kral et al., 1968; Miller & Lieberman, 1965). Whether the results were expressed in terms of higher mortality rates, decreased social adjustments, increased life dissatisfaction, and so forth, all these studies supported the same conclusion.

However, neither Gutman and Herbert (1976) nor Borup et al., (1979) corroborate these findings. Gutman and Herbert (1976), found their most vulnerable subjects to be ambulatory elderly as compared to the nonambulatory ones. Additional emotional support given to nonambulatory residents was advanced as a reason for the observed results. As for Borup et al., (1979), they concluded that there was no significant difference in mortality rate when they compared relocated elderly suffering from a physical handicap and nonhandicapped relocated elderly.

As stated earlier, gender has been observed to be an individual characteristic which modifies the degree of stress due to forced relocation. Some researchers (Kral et al., 1968; Pablo, 1977) have asserted that institutionalized males were the ones who were most vulnerable to the impact of forced relocation, while Borup (1981) found females to be the group most affected by this stressful experience. Others (Borup et al., 1979; Markus et al., 1971) found no correlation between gender and the degree of vulnerability to the negative effects of involuntary relocation.

Lastly, a study which included expressiveness as a variable must be mentioned. Aldrich (1964) reported that institutionalized elderly who were able to express their anger and apprehension when confronted with relocation, had better chances of surviving post-relocation than psychotic

individuals or those affected by other personality disorders. Aldrich concluded this by first categorizing residents according to the predominant personality characteristic. Then, he observed their emotional response when the residents were informed of the move. Afterwards, mortality rates were recorded. Thus, it seems that expressiveness as a personality factor affecting one's emotional response to forced relocation is associated with survival post-relocation.

Involuntary relocation and attitudes. Except for one specific question by Brody et al., (1974) and Borup (1981) regarding the person's attitude toward the move, the concept of attitude is virtually absent from the literature on forced relocation. Borup (1981) interviewed long-term care residents when these were informed that they had to move to another institution (T_1) and asked them how happy they were about the move. He compared these answers to the answers these same relocated elderly gave 2-3 weeks after the move (T_2), and then, 3-6 months later (T_3). He found over 1/3 of the residents to be upset at T_1 but by T_3 only 13% were still upset. When controlling for gender and age, females were observed to be more upset at T_1 and T_2 than their male counterparts, and those 80 years of age and older to be more upset at T_2 than those under 65 and those between 65 and 79. At T_3, no gender nor age difference were observed. As for their willingness to move, females

had a higher percentage who wanted to move (43%) and who wanted to stay (33%), whereas males had twice the percentage who were indifferent (43%) to the move. It was concluded that attitudes are usually negative at the time when long-term care residents are informed of impending relocation and at the time of relocation, especially for females and those 80 years old and over. But when settled into their new institutional environment, the residents' attitudes became more positive.

Brody et al., (1974) assessed attitudes toward forced relocation by asking social workers to observe and rate residents' attitudes who were forced to relocate on a 7-point rating scale ranging from very displeased to very pleased. As in Borups' study, the subjects were rated on three separate occasions: when informed of the move (T_1), two weeks after the move (T_2) and four months later (T_3). Brody and her colleagues found that attitudes toward relocation went from being mildly to moderately negative at T_1, to approaching the neutral point at T_2, to having reached the neutral or no reaction point at T_3. Thus negative attitudes toward relocation had dissipated four months after relocation took place.

Instruments and methodology. As mentioned throughout this literature review, researchers interested in the subject of involuntary relocation have measured its impacts in terms of death rates, health status measures, life

satisfaction scales, social adjustment scales, and so forth. Except for a few questions addressing long-term care residents' attitudes toward forced relocation, an instrument specifically measuring attitudes has yet to be developed.

In addition to different measuring instruments, researchers utilize different designs and time frames. Often, characteristics of the subjects are not fully documented. Furthermore, the conditions of relocation and the degree of environmental changes are not completely described. Thus replication of research conditions and of methodological designs is almost impossible.

Summary. This review has outlined the main points from the existing literature on involuntary relocation thereby summarizing the present state of knowledge about this topic. It has established the contextual situations from which involuntary relocation has been studied and has presented the different variables considered by researchers to be linked to this event.

Factors like ethnic identification, location of spouse, self-report of emotional support from a significant other, and length of stay in a nursing home are variables which have been omitted from previous research. This evaluative research has included those variables. As a result, insights are gained.

Conclusion

A merger of the literature on evaluation with studies examining involuntary relocation presents some advantages. First, to consider a specific gerontological area from an evaluation perspective increases the awareness of politicians and program directors to the impacts of policies and programs they develop. Valuable insights are gained about the effects of social changes as generated by new policies or new social programs.

Second, to evaluate impacts of a social program designed for the institutionalized population promotes the inclusion of evaluation as a necessary step of programming. In other words, publication of findings serves as an incentive for policy-makers and program directors to evaluate social programs. This process is relevant not only insomuch as it helps to detect program impacts, but as it provides descriptive and statistical data which is instrumental in the refinement of social programs. Furthermore, such findings serve to broaden the scientific base of knowledge of social programs for the elderly population.

Third, the most significant contribution of this research project is that it addresses attitudes of prospective relocated persons, a topic virtually ignored in the existing literature. As attitudes are suspected to be an important variable of successful relocation and

adjustment post-relocation, such exploration of attitudes is important because it provides direction for future research.

Chapter Four

Methodology

Sampling Procedures

The sampling process consisted of four steps. First, the researcher met individually with all the nursing home administrators in order to acquaint them with the study and obtain their permission to conduct part of the study in their facility. In the situation where two or more nursing homes had the same ownership, the owner or the regional or executive director was personally contacted for authorization prior to meeting with the administrators. Second, when permission was granted, the researcher requested the administrator to designate one or more staff members who had frequent contacts with the residents and who could identify suitable subjects for this study, for example, head nurses or team leaders. Third, the researcher met with those appointed by the administrators on an individual basis. They were asked to identify the nursing home residents who were suitable for this study and submit a list of residents' names. The standards specified for the identification of respondents were that these individuals were nursing home residents who had the physical and mental abilities to answer a short

questionnaire, and who were fluent in English. In District No. 24, these residents were also required to have been in the R/A program long enough to have been reassessed by the CPO nurse on at least one occasion. Fourth, from the lists submitted by all nursing homes which agreed to take part in this study, the researcher chose every second name, thereby selecting a representative sample.

The population consisted of nursing home residents within the geographical boundaries of District No. 24. The total number of nursing home residents is 2,463. Out of 19 nursing homes, 16 participated in the study. The researcher eliminated one facility because of its atypical population. One administrator did not wish to have two facilities take part in the study. In all, 677 names were submitted to the researcher. One nursing home was chosen to pilot the project. Thus, the experimental group consisted of 330 nursing home residents.

In order to determine long-term impacts of the R/A program on its recipients, a comparison group was required. Nursing home residents within the geographical boundaries of District No. 7, which includes the city of Calgary, made up the comparison group. The reason for selecting District No. 7 as a comparison group was twofold. On the one hand, District No. 7 differed from District No. 24 to the extent that there was no R/A program in place. No routine reassessments of nursing home residents by a CPO nurse had

taken place. On the other hand, there were many similarities between the two districts. Edmonton and Calgary are urban centers where the population exceeds 500,000. Both cities are similar insofar as industrial growth, business activities and touristic attractions. More importantly, both District No. 24 as well as District No. 7 monitor admission of individuals to nursing homes from a Central Placement Office. Though Calgary was found upon investigation to be piloting a new governmental assessment and placement model, applicants were still assessed by a CPO nurse according to criteria specified by the Nursing Homes Act (1970, 1985), thereby ensuring regulation of admissions. The total number of nursing home beds in District No. 7 is 2,207, a number comparable to that of District No. 24. Thus, District No. 7 was comparable to District No. 24 in terms of its population and social environment, the presence of CPO to monitor admissions into nursing homes, and the number of nursing home beds. The same identification and selection procedures for the comparison group were followed as those described for the experimental group, except for involvement in a R/A program.

In District No. 7, 16 nursing homes out of 17 took part in the study. One administrator refused to have one facility take part in this research. Altogether, 714 names were submitted, so a total of 357 nursing home residents

were selected for the comparison group.

Instrument

A 26 item questionnaire (see Appendix C) was developed for this project. The same instrument was used for the comparison group except the last three questions were deleted from the B section. Two-category closed questions giving respondents the choice between answering yes or no were designed to elicit the subjects' attitudes toward involuntary relocation. Responses were scored by giving 5 points to questions 1, 2, 3, 4, 7 and 11, when the respondents answered these in the affirmative and by giving 5 points to questions 5 and 6 when the respondents answered these in the negative. Summing the points, an index of the subjects' attitudes toward involuntary relocation was produced. The possible scores ranged between 0, indicating the most negative attitude toward involuntary relocation, and 40, indicating the most positive attitude toward forced relocation.

As this questionnaire was being utilized for the first time, face validity was established by a group of experts. This group, formed by four assessment nurses, a long-term care planner from the Alberta Social Services and Community Health (Home Care Unit), and a representative of the Alberta Association of Registered Nurses, reviewed each question. The researcher invited each member to comment

and to conclude whether the questions measured attitudes of nursing home residents regarding involuntary relocation.

The reliability was tested by the split-half method. The items were separated according to the even-odd and similarity of items principles. The Guttman split-half reliability coefficient computed was .46. Applying the Spearman-Brown prophecy formula which corrects the split-half reliability coefficient and adjusts it for the whole test (Ferguson, 1981; Polit & Hungler, 1978; Schmidt, 1979), the corrected reliability coefficient was .63. A reliability coefficient of .70 is "usually considered respectable" (Henerson et al., 1978, p. 153), especially when attitude measurements are considered.

The questionnaire was pilot-tested by administering it to a group of respondents (n = 5) identified by the sampling procedure. The pilot study was conducted to assess if question wording was clear and well understood by the elderly respondents.

The face validity procedure and the pilot study permitted the researcher to make appropriate revisions; question wording and sequence were changed. Individual interviews were conducted instead of group interviews to facilitate the process of administering the questionnaire.

Data Collection

The subjects were invited by letter (see Appendix D)

to participate in the study. This letter informed them of the method chosen to collect the data as well as the date, time and place the researcher would meet with them. The researcher met the interested participants individually in their respective nursing homes. The procedure for collecting the data is outlined in Appendix E.

First the researcher introduced herself and acquainted the participant with the general purpose of the study. The participant was informed that he/she could withdraw from the study at any time. It was stressed that there were no right or wrong answers. It was emphasized that answering this questionnaire would in no way influence the respondent's present or future level of care. The respondent was assured that individual results would be kept confidential as the questionnaire did not bear specific identification, and that only group data would be available to those other than the researcher. Eventhough the respondents implied their agreement to participate in the study by having agreed to respond to the written invitation handed out to them, a written consent was obtained from each respondent (see Appendix F).

The questions and response alternatives were read aloud while the respondent read along. The researcher checked off the line beside the answer given by the respondent. Generally, the interview lasted 15 to 20 minutes.

It should be noted that respondents in the experimental

group were able to identify the R/A nurse either by name or by describing her function. As for the comparison group, when the CPO (called Care West in District No. 7) was mentioned, the respondents knew that nurses working for that agency were the ones responsible for establishing the level of care of applicants.

After completion of the questionnaire the researcher debriefed the respondent by informing him/her of the specific purpose of the study (see Appendix E). The researcher remained available to answer any questions or deal with any concerns the participants had. In one instance a subject was observed to be disturbed. The charge nurse was notified and the situation was resolved. Respondents in the experimental group were informed of an optional follow-up session which will take place in the near future. At this supplementary meeting, results will be shared with the participants and other nursing home residents who are interested. Respondents in the comparison group were told that a copy of the results would be sent to the administrator. Subsequently, an optional follow-up session would take place in their own facility. Lastly, nonparticipants, for example, roommates, were told of the sample selection procedure when these individuals made such inquiries. It should be noted that the data collection procedures described and the ethical considerations mentioned throughout this section were followed for both experimental and comparison groups.

Chapter Five

Data Analysis

Descriptive Statistics

Table 1 classifies those who were initially selected to participate in this study into respondents and non-respondents. In addition, it gives a condensed list of reasons and circumstances which explains why some nursing home residents did not take part in this study. It is interesting to note that among those who refused to take part in this study, seven did so because they felt uncomfortable signing a consent form. Of those, some had an appointed legal guardian, others wanted one of their adult children to first agree with the project before answering the questionnaire. A few others were simply afraid that signing a form would automatically oblige them to some monetary contribution or to some future involvement.

Table 1

Distribution of Prospective Respondents

Categories	Experimental Group N: 330 n	%	Comparison Group N: 357 n	%	Total n
Respondents	181	55	183	51	364
Refused	105	32	123	34.5	228
Deceased	3	1	1	.5	4
Hospitalized and Ill[a]	11	3	19	.5	30
Absent[b]/Discharged	5/4	3	6/5	3	11/9
Eliminated[c]	21	6	13	4	34
Withdrew/Missing[d]	--	--	1/6	2	1/6
Total	330	100	357	100	687

[a]Residents who were not contacted as charge nurse told researcher they had become ill.

[b]Residents who were not in the building when data were collected.

[c]Residents who were eliminated by researcher due to mental and or physical deterioration.

[d]Names submitted to researcher which were missing from original lists.

Table 2 reports the scores of the experimental and comparison groups.

Table 2

Attitude Score Re:' Involuntary Relocation

Score	Experimental Group n	%	cumm. % freq.	Comparison Group n	%	cumm. % freq.	Total n
0	2	1	1	1	1	1	3
5	6	3	4	8	4	5	14
10	16	9	13	16	9	14	32
15	31	17	30	31	17	31	62
20	40	22	52	40	22	53	80
25	40	22	74	41	22	75	81
30	25	14	88	30	16	91	55
35	17	10	98	13	7	98	30
40	4	2	100	3	2	100	7
Total	181	100		183	100		364

$\underline{X}$ = 21.88 S.D. = 8.44

$\underline{X}$ = 21.67 S.D. = 8.19

The information gathered regarding respondents' characteristics can be found in Appendix G to Appendix L. Also the mean, the standard deviation, the range and the mode of respondents' age and length of stay in the nursing home are presented in Appendix M.

Statistical Analysis

For the purpose of statistical analysis, null hypotheses were derived from the questions stated in chapter one.

> There will be no difference in attitudes toward involuntary relocation between nursing home residents who are recipients of the R/A program implemented in District No. 24, and nursing home residents who are not part of the R/A program, that is, residing outside of District No. 24.
>
> There will be no relationship between nursing home residents' attitudes regarding involuntary relocation and nursing home characteristics.
>
> There will be no relationship between nursing home residents' attitudes held about involuntary relocation and respondents' characteristics.

To make comparisons between the experimental group and the comparison group, in terms of their attitudes toward involuntary relocation, group means were compared using General Linear Model procedures (SAS, 1985). The analysis of variance did not uncover a significant difference between the two groups' means. Consequently, the first null hypothesis was not rejected.

The second null hypothesis which predicted that nursing home characteristics would not affect attitudes of institutionalized elderly toward involuntary relocation was tested by mathematically deriving F-ratios using General Linear Model procedures (SAS, 1985). The only effect which approached significance was ownership [$F(2, 361) = 2.68$, $p = .07$]. F-ratios for hometype and location were not statistically significant. Thus, the null hypothesis was

not rejected.

Other F-ratios were calculated using the General Linear Model procedures (SAS, 1985) in order to analyze if respondents' characteristics such as age, gender, ethnic and religious identification, marital status, self-report of emotional support, number of moves after age 40 and before being institutionalized and length of stay in a nursing home, were related to the attitudes of nursing home residents regarding involuntary relocation. The only respondent characteristic which reached statistical significance was age [$F(1, 333) = 9.08$, $p = .002$]. Regression analysis showed that age was inversely related to positive attitudes regarding involuntary relocation [$F(1, 360) = 11.08$, $p = .001$].

To further explore the data, post hoc analyses were done. As the R/A program has direct repercussion on the family in terms of increased interfacing with family members, especially when relocation is suggested, attention should be given to the analysis of the following question: Would you be willing to move out of this nursing home into another institution if your family suggested you do so? A Chi-square test applied to the data collected from the experimental and comparison groups showed the distribution of Yes/No answers between the two groups to be statistically significant [X^2 (1, $N = 355$) = 7.30, $p = .007$]. Table 3 indicates that a larger percentage of

respondents in the experimental group than in the comparison group, would be willing to move if their family made such a suggestion.

Table 3

Question 10 by Group

Answer	Experimental Group n	%	Comparison Group n	%	Total n
Yes	95	54	71	40	166
No	81	46	108	60	189
Total	176	100	179	100	355

Frequency Missing = 9

The above statistical analyses revealed that age is a factor which affects attitudes held by nursing home residents in regards to involuntary relocation. Also a significant Chi-square established a statistical relationship between the experimental and comparison groups when the distribution of answers to the question discussed above are considered.

Chapter Six

Discussion

This chapter presents a discussion of the statistical results as they relate to the original questions. Interpretation of the findings point to some practical and theoretical implications as well as certain areas for further studies. Systems theory is used as the framework for discussing these dimensions.

Interpretation of Findings

Statistical testing of the data collected to answer one question asked in this study resulted in no statistically significant differences in attitudes toward involuntary relocation between two groups of institutionalized elderly. It is possible to speculate that this finding may be the result of a number of intervening variables which are discussed in the following paragraphs.

First, negative attitudes may have predominated when the R/A program was first implemented. In other words, negative attitudes may have been observed in the experimental group if primary impacts or initial reactions toward involuntary relocation had been measured. As was

observed by Borup (1981) and Brody et al. (1974), attitudes of institutionalized elderly who were told about having to relocate, shifted from being negative when first informed, to being neutral or positive six months post-relocation. Thus, it may be conceivable that a similar pattern is evident when institutionalized elderly are recipients of a program that may recommend relocation: initial negative attitudes become neutral or positive with time.

Second, that the experimental group did not score in a more negative direction than the comparison group may be attributed to the fact that the program recipients are now well informed about the R/A program. As the R/A program is in its third year, the program recipients are able to rely on factual information about the program activities and outcomes, instead of ambiguous rumors. Thus, accurate relocation information may be seen as another factor which explains the present results.

Third, that the scores of the comparison group are similarly distributed to those of the experimental group may reflect the appropriateness of the data collection protocol and the ethical considerations given in this study. For example, considerable care was taken when the questionnaire was administered so that respondents were well aware that they were participants in a research project. This strategy may have secured the respondents to the extent that though relocation was discussed, it was not

perceived as a threat.

As the reader can see, the above factors may have influenced the results. Thus, the time factor combined with accurate information may be the variables which have facilitated neutral and positive attitudes toward involuntary relocation in the experimental group. It should also be mentioned that the instrument had adequate face validity. However, the lack of internal consistency may have accounted for the lack of statistical significance between the two groups.

The second question queried the relationship between attitudes about involuntary relocation held by nursing home residents and nursing home characteristics. There was no statistical significant differences between the two groups. Thus, this study failed to isolate variables that relate statistically significantly to the program implementation environment.

The last question asked if there was a relationship between respondents' characteristics and their attitudes toward involuntary relocation. The results suggested that age was the only statistically significant respondent characteristic. It was found to be inversely related to positive attitudes about involuntary relocation. This finding is consistent with Borup (1981) who indicated that with increasing age, attitudes of institutionalized elderly about involuntary relocation became more negative. This

finding can also be explained by citing the literature that says that the physically handicapped and those in poor physical and/or mental health are the most vulnerable to involuntary relocation (Aldrich, 1964; Borup et al., 1979; Brody et al., 1974; Killian, 1970; Kral et al., 1968; Miller & Lieberman, 1965). Therefore, increased vulnerability to involuntary relocation may also increase with age; and this vulnerability could manifest itself by more negative attitudes toward involuntary relocation.

As for the reported Chi-square, it showed that a greater proportion of respondents in the experimental group than in the comparison group were willing to move out of the nursing home if a family member made such a suggestion. This finding may substantiate the positive aspect of increased interfacing which takes place between the institutionalized elderly, their family members, and the CPO assessment nurses as a result of the R/A program activities. This outcome of the R/A program may be instrumental in improving the quality of the relationship between institutionalized elderly and their family. It is reported in the literature that the family provides the major social and psychological support for the elderly (Shanas, 1979). Thus, increased interfacing between the generations may lead to positive results.

Furthermore, it is also possible that the additional interactions taking place between the CPO nurses and the

family of institutionalized elderly may be beneficial for family members. It may provide them with the opportunity to ventilate feelings associated with old conflicts which resurface when increased interfacing between family members occurs (Weishaus, 1979). Also, feelings of guilt and anxiety often generated by the decision to institutionalize an older person, or later by the prospect of relocation, may be effectively dealt with when the CPO nurses interface with family members using a therapeutic approach (Kirschner, 1979). Thus, the R/A program may promote satisfying family relationships, something which is regarded as important by older persons (Blazer, 1978).

Implications and Recommendations

The following implications are from a practical and theoretical perspective. They are limited to the interviewable population in nursing homes from which the data were collected. This population (n = 677) consists of nursing home residents who have the physical and mental ability to answer a short questionnaire and who are fluent in English. They can be generalized to other institutionalized elderly only to the extent that they are known to be comparable to the sample population.

The findings of this study indicate that age is inversely related to positive attitudes about involuntary relocation. Therefore, caution should be exercised when

relocating the very old. Whenever possible, alternate arrangements should be made instead of relocating a very old person. This particular situation calls for innovative and creative thinking on the part of professionals involved in the relocation of institutionalized elderly. But more so, it also requires a professional involvement marked by respect and compassion for older persons.

Additional findings also suggest that the family is particularly important for the institutionalized elderly. Thus, intergenerational relationships should be promoted. When conflictual family situations are recognized, counseling services should be suggested.

The implications of this study can also be considered from a theoretical perspective. When a program is evaluated using general systems theory, the following implications are appropriate. Since input is a key concept in the general systems theory, competent programmers give careful thought to external influences which compel them to develop a particular program. However, individuals who are affected by program output are not necessarily aware of such influences. Thus, it should become a responsibility of program developers to inform those, who are affected by the program, of the societal influences which led to the development of the new program. In addition to giving facts and providing a rationale, this strategy may work in favor of program acceptance if information is disseminated

before a program is put into place.

Various approaches can be suggested to inform program participants about societal influences. For instance, nursing home-based information sessions would be an appropriate means for health professionals to present relevant long-term care issues to institutionalized elderly, their family and nursing home workers. Such sessions could also include program directors introducing new programs.

Institutionalized elderly should also be encouraged to form self-help groups and support networks to help them cope with the changes produced by a program like the R/A program. This would provide them with the opportunity to discuss a variety of issues and concerns. Moreover, it would allow them to share how they feel about the changes resulting from a new program. Peer-counseling is another approach which has the potential to facilitate the resolution of problems associated with changes that affect institutionalized elderly.

These approaches would not only be a means to transmit concrete and practical information but may contribute to the necessary climate which is conducive to the promotion of a more realistic image of institutionalized elderly. Nursing homes would no longer be seen as a last haven, but as institutions offering the potential for rehabilitation (Provincial Senior Citizens Advisory Council, 1981).

Explicit throughout this study is the importance of evaluation as an integral component of programming in that information about outcomes and impacts should be fed back to the system. Ideally, evaluation should be formative or ongoing during the whole course of a program. Program directors would then be aware of ineffective program components and could make the necessary adjustments, thereby improving a program.

Before concluding, some possibilities for future research areas follow. Researchers interested in attitudes about involuntary relocation should consider the following factors: attitudes of long-term care workers, of doctors, of family members toward involuntary relocation; satisfaction of nursing home residents with present level of care; and self-report by nursing home residents of health status. An effort should also be made to collect pertinent data from nursing home residents over an extended time period, with the intent of establishing baseline data from which future program outcomes and impacts could be compared. Further exploration is also required to develop an instrument which would measure the degree of vulnerability of institutionalized elderly to environmental changes. Finally, studies are needed to compare the effects of relocating institutionalized elderly to a lower level of care with the effects of relocation to a higher level of care.

To researchers who are interested in collecting data from institutionalized elderly, some directions are noted. It is advantageous for the researcher to be extremely familiar with the long-term care environment as well as the population living in long-term care institutions. Problems can be foreseen and averted. This would enable the researcher to determine if the interview should actually take place. Also, individual administration of questionnaires is preferable as it gives the researcher the opportunity to deal with physical deficits of institutionalized elderly on a personal basis.

In conclusion, one can say that program evaluation is an important endeavor. It permits the identification of factors which should be considered when programs are developed and implemented, if certain outcomes and impacts must be achieved. In other words, evaluative research is part of the feedback mechanism which gives program directors some concrete data on which to base future decisions. When social programs are concerned, the information fed back to the system should be considered from a humanistic perspective. That is, attempts should be made to gain a greater understanding of how program outcomes and impacts affect human beings. Thus, program revisions can be made, or new programs developed with a real concern for people. This perspective may prove to be the most successful one and from which social programs may have most positive impacts.

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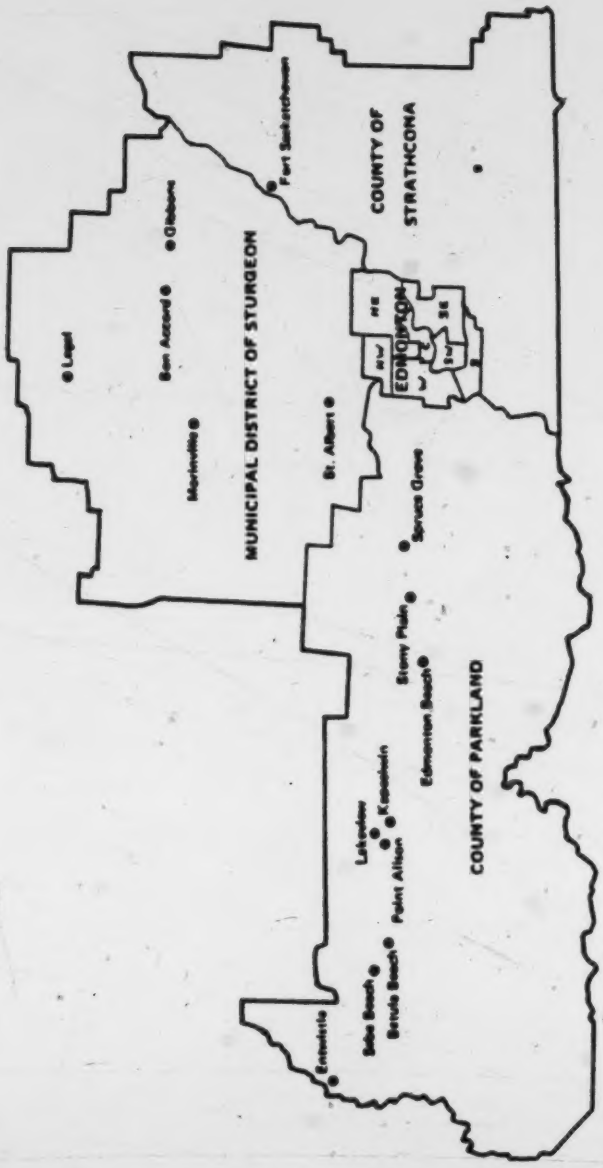
APPENDIX

Appendix A

Geographical Boundaries of District No. 24



Appendix B

Definition of Levels of Care

I. Assessment and Rehabilitation

This level of care pertains to patients with a disability not requiring acute treatment, but who can benefit from a planned intensive and comprehensive program of mental or physical rehabilitation. This category requires constant assessment but patients should continue in this category as long as they are making progress, even though the final objective may fall short of total independence, or may result in a need for eventual institutional care at a lower level. This level is available in hospitals with an organized department of physical or mental rehabilitation.

II. Extended (Auxiliary) Hospital Care

This level of care is for persons of all ages who do not require acute hospital care and treatment nor an intensive or comprehensive program of rehabilitation but who do require regular and continuous medical attention, skilled technical nursing provided under appropriate supervision on a 24-hour basis and, in addition, special techniques for the improvement or maintenance of function.

Patients at this level require initial and continuing medical assessment involving investigation and diagnosis for which appropriate facilities must be readily available. The aims of treatment are to control the disease process,

to achieve maximum recovery of function to prevent further disability, to retard deterioration, and to alleviate pain and distress.

There are two aspects to this type of care:

(a) Supportive Care

This relates to persons with advanced chronic illnesses or disabilities who require skilled nursing care on a 24-hour basis under medical supervision, and/or specialized techniques to arrest or retard deterioration and would include mentally unstable, physically disabled patients.

(b) Restorative Care

This relates to persons with chronic illnesses or disabilities whose general condition is such that they could not withstand an intensive and vigorous rehabilitation program, but who can benefit from a slower paced restorative regime designed to improve functional ability either for continued care at this level or to the extent that they can be cared for at home or at a less intensive level of care.

This level of care is available in auxiliary hospitals throughout the province.

III. Nursing Home Care

There are two aspects to this type of care:

(a) Intensive Personal Care with Nursing Supervision

This level of care is usually associated with the

patient having advanced physical or mental illness that is reasonably stabilized and which is not expected to deteriorate in the near future (barring the occurrence of an additional disease or an accident). While personal care attendance is required on a 24-hour basis, the nursing supervision need not be. Care is usually given by auxiliary nursing personnel.

The care of the resident is to be carried out under the supervision of a registered nurse as directed by a physician. A heavy concentration of graduate nurses in such an institution is not required because the need is primarily for personal services rather than skilled nursing; however, general supervision by a registered nurse is necessary.

- Physical Status: Residents in this category either show evidence of aging changes combined with chronic disease, or regardless of their age, need assistance because of the advanced stage of their chronic illness.
- Emotional and Mental Status: This level of care will include residents suffering from varying degrees of mental deterioration resulting from senility, mental retardation, or psychiatric disorders but will exclude residents having characteristics of serious mental or emotional

problems who might be harmful to themselves, harmful or threatening to others, or destructive of property. The resident may require close supervision because of restlessness or a tendency to wander occasionally.

- Mobility: Ambulant, semi-ambulant, confined to a wheel chair, chair-fast, or bed-fast.
- Meals Required: Special diets and tray services are common; residents will require varying degrees of assistance with eating. However, this level of care will exclude residents with conditions necessitating the taking of nutritional requirements other than by mouth (for example, nasal gastric tube feeding, intravenous, etc.) of those with physical difficulty in swallowing who are in danger of food or drink entering the air passages.
- Health Care Supervision Required: The resident is fully or partly dependent in regard to self care. He may also require professional nursing but only as an adjunct to personal care. This level of care would include assistance with bathing, grooming, eating and dressing, administration of drugs, care of incontinent persons, and simple exercises, but would not include such procedures as intravenous and oxygen therapy on a continuous

basis. In most cases residents will require the administration of prescribed medication and periodic medical or psychiatric reviews. Residents may require simple rehabilitation measures designed to reactivate them or maintain the highest possible level of function.

(b) Limited Personal Care

This level of care is for residents who are slowing down in physical functions and/or mental faculties and therefore require supervision and some assistance with activities of daily living and administration of medications.

Both levels of care described under (a) and (b) of this section are available in all contract nursing homes throughout the province.

IV. Homes for the Aged

This level of care is for residents who need room, board and laundry service only.

From: Assessment and Admissions form - HS 021-082.

Appendix C

Questionnaire

Date: _____

QUESTIONNAIRE - NURSING HOME RESIDENTS

A. OPINIONS (Experimental and comparison groups)

1. Do you think nursing homes could be used on a short-term basis in addition to a permanent basis?

   YES _____ NO _____

2. Do you think that people who have lived in a nursing home will ever be able to manage outside an institution?

   YES _____ NO _____

3. Do you think it would be fair if anyone told you to move out of this nursing home?

   YES _____ NO _____

4. If the assessment nurse from Central Placement Office suggested to you that you do not need the help available in a nursing home, would you be willing to move out of this institution?

   YES _____ NO _____

5. If the assessment nurse from Central Placement Office suggested to you that you do not need the help available in a nursing home, would you be less willing to do things for yourself instead of having to move out?

   YES _____ NO _____

6. If the assessment nurse from Central Placement Office suggested to you that you have to move to an auxiliary hospital, would you try to do more things for yourself instead of having to move out?

YES _____ NO _____

7. If the assessment nurse from Central Placement Office suggested to you that you needed more care than the staff can give you in a nursing home, would you be willing to move to an auxiliary hospital?

YES _____ NO _____

8. Would you be willing to move out of this nursing home if you decided to do so yourself?

YES _____ NO _____

9. Would you be willing to move out of this nursing home if your doctor suggested you do so?

YES _____ NO _____

10. Would you be willing to move out of this nursing home into another institution if your family suggested you do so?

YES _____ NO _____

11. Would you be willing to move out of this nursing home if the assessment nurse from Central Placement Office suggested you do so?

YES _____ NO _____

B. PERSONAL AND SOCIAL INFORMATION (Experimental group)

1. Place of birth: _____ (CITY/TOWN), _____ (PROVINCE),
_____ (COUNTRY)

2. When were you born? _____ (MONTH), _____ (YEAR)

3. Sex: _____ MALE _____ FEMALE

4. With what religion do you identify?
_____ PROTESTANT
_____ CATHOLIC
_____ EASTERN ORTHODOX
_____ OTHER, PLEASE SPECIFY: _____
_____ NONE

5. With what ethnic origin do you identify?
_____ BRITISH
_____ GERMAN
_____ UKRAINIAN
_____ FRENCH
_____ OTHER, PLEASE SPECIFY: _____
_____ NONE

6. Are you:
_____ MARRIED
_____ SEPARATED
_____ DIVORCED
_____ WIDOWED
_____ SINGLE

7. If married, where does your spouse live?
_____ IN THIS BUILDING
_____ IN AN AUXILIARY HOSPITAL
_____ ELSEWHERE, PLEASE SPECIFY: _____

8. Do you receive emotional support from a significant other?

YES _____ NO _____

9. Does that person usually get to this nursing home by:

_____ WALKING

_____ TAKING A BUS

_____ DRIVING HIS/HER OWN CAR

10. Do you believe that person would continue to give you support if you were to more out of this nursing home?

YES _____ NO _____

11. Since the age of 40, how many times have you moved before entering into a nursing home?

_____ NEVER

_____ A FEW TIMES (1 TO 3 TIMES)

_____ MANY TIMES (4 TIMES OR MORE)

12. How long have you lived in this nursing home?

_____ YEARS _____ MONTHS

13. Have you ever been told by the assessment nurse from Central Placement Office that you needed more care than this nursing home can provide?

YES _____ NO _____

14. Have you ever been told by the assessment nurse from the Central Placement Office that you needed less care than is available in this nursing home?

YES _____ NO _____

15. Have you ever had to move because an assessment nurse from Central Placement Office suggested to you that you should do so?

YES _____ NO _____

Thank You!

Lise J. Boucher
University of Alberta
Department of Family Studies
801 General Services Building
Edmonton, Alberta
Phone: 432-5771

Participant No. _____

Nursing Home No. _____

B. PERSONAL AND SOCIAL INFORMATION (Comparison group)

1. Place of birth: _____ (CITY/TOWN), _____ (PROVINCE),
_____ (COUNTRY)

2. When were you born? _____ (MONTH), _____ (YEAR)

3. Sex: _____ MALE _____ FEMALE

4. With what religion do you identify?
_____ PROTESTANT
_____ CATHOLIC
_____ EASTERN ORTHODOX
_____ OTHER, PLEASE SPECIFY: _____
_____ NONE

5. With what ethnic origin do you identify?
_____ BRITISH
_____ GERMAN
_____ UKRAINIAN
_____ FRENCH
_____ OTHER, PLEASE SPECIFY: _____
_____ NONE

6. Are you:
_____ MARRIED
_____ SEPARATED
_____ DIVORCED
_____ WIDOWED
_____ SINGLE

7. If married, where does your spouse live?
_____ IN THIS BUILDING
_____ IN AN AUXILIARY HOSPITAL
_____ ELSEWHERE, PLEASE SPECIFY: _____

8. Do you receive emotional support from a significant other?
YES _____ NO _____

9. Does that person usually get to this nursing home by:

_____ WALKING

_____ TAKING A BUS

_____ DRIVING HIS/HER OWN CAR

10. Do you believe that person would continue to give you support if you were to more out of this nursing home?

YES _____ NO _____

11. Since the age of 40, how many times have you moved before entering into a nursing home?

_____ NEVER

_____ A FEW TIMES (1 TO 3 TIMES)

_____ MANY TIMES (4 TIMES OR MORE)

12. How long have you lived in this nursing home?

_____ YEARS _____ MONTHS

Thank You!

Lise J. Boucher
University of Alberta
Department of Family Studies
801 General Services Building
Edmonton, Alberta
Phone: 432-5771

Participant No. _____

Nursing Home No. _____

University of Alberta
Edmonton
Canada T6G 2H1

Department of Family Studies
Faculty of Home Economics
501 General Services Building, Telephone (403) 432-3771

Appendix D

Letter to Participants

<DATE>

<Participant's name>
<Nursing Home>
Edmonton, Alberta
<Postal Code>

Dear Mr./Mrs. <NAME>:

I am a graduate student at the University of Alberta in the Department of Family Studies. I am very interested in the aging family and its older members. I have a nursing background, and the life of aging family members who need the support of nursing home care is also very interesting to me. At the present time, I have no professional connections with the government or this institution.

Your participation in a research project exploring one aspect of nursing home life is being requested. The nursing home administrator <NAME> is aware of this research and has granted <HIS/HER> permission to conduct part of the study in this nursing home.

Your experience as a nursing home resident is very valuable to me and if you are interested, I would appreciate your sharing it with me by answering a short questionnaire. I am looking forward to meeting you on <DAY> the <DATE> at <TIME> in the <PLACE>.

Thanking you in advance for your cooperation.

Sincerely yours,

Lise J. Boucher

Appendix E

Data Collection Protocol

A. Meeting with participant.

- introduction of researcher and of general purpose of study
- reading of informed consent form to participant by researcher as participant read own copy
- signature of informed consent form by participant

B. Administration of questionnaire.

- reading of individual questions to participant by researcher as participant read own copy, followed by the giving of appropriate explanations by researcher
- checking of blanks

C. Debriefing mechanism.

- communication to participant of specific purpose of research
- communication to participant of optional follow-up session to share results
- expression of gratitude by researcher to participant for having taken part in the research

Appendix F

Informed Consent

Thank you for responding to my invitation to take part in this study. I am a graduate student at the University of Alberta in the Department of Family Studies. I am very interested in the aging family and its older members. I have a nursing background, so the life of aging family members who need the support of nursing home care is also very interesting to me.

This questionnaire was designed to study one aspect of nursing home life. It consists of 26 questions and it will take you about one hour to complete it. There are no right or wrong answers. Your life at the nursing home will in no way be influenced by answering these questions. I will read each question to you, so it will be easy for you to answer this questionnaire. If you feel tired or do not feel well while answering these questions, let me know and we will take a short break. You may withdraw at any time from this study.

When you have completed the questionnaire, I will explain to you the purpose of this study. If you have any questions I will be pleased to answer them. When all the results of this study are compiled, I will come back here and if you are interested, I will share these results with you.

Thank you for taking part in this study. Your life in a nursing home is a valuable experience and I appreciate your sharing it with me.

Date: _____

Signature: _____

Lise J. Boucher
University of Alberta
Department of Family Studies
Edmonton, AB
Phone: 432-5771

Appendix G

Table 1

Respondents' Gender

	Experimental Group		Comparison Group		Total
	n	%	n	%	n
Male	68	38	51	28	119
Female	113	62	132	72	245
Total	181	100	183	100	364

Table 2

Respondents' Place of Birth

Place	Experimental Group		Comparison Group		Total
	n	%	n	%	n
UK	30	17	48	26	78
Alberta	55	30	46	25	101
Canada (-Alta)	51	28	56	31	107
Other	45	25	33	18	78
Total	181	100	183	100	364

Appendix H

Table 1

Respondents' Ethnic Identification

Ethnic Group	Experimental Group n	%	Comparison Group n	%	Total n
British	66	36	107	58	173
German	18	10	15	8	33
Ukrainian	22	12	2	1	24
French	13	7	5	3	18
Canadian	34	19	38	21	72
Other	28	16	14	8	42
None	0	0	2	1	2
Total	181	100	183	100	364

Appendix I

Table 1

Respondents' Religious Identification

Religion	Experimental Group n	%	Comparison Group n	%	Total n
Protestant	131	73	142	78	273
Catholic	38	21	27	15	65
Eastern Orthodox	6	3	1	1	7
Other	2	1	6	3	8
None	4	2	6	3	10
Total	181	100	182	100	363

Frequency Missing = 1

Appendix J

Table 1

Marital Status of Respondents

Marital Status	Experimental Group n	%	Comparison Group n	%	Total n
Married	26	14	22	12	48
Separated	9	5	13	7	22
Divorced	12	7	12	7	24
Widowed	109	61	114	62	223
Single	24	13	22	12	46
Total	180	100	183	100	363

Frequency Missing = 1

Appendix K

Table 1

Self-report of Emotional Support

	Experimental Group		Comparison Group		Total
	n	%	n	%	n
Yes	163	90	164	93	327
No	18	10	12	7	30
Total	181	100	176	100	357

Frequency Missing = 7

Appendix L

Table 1

Number of Moves: From Age 40 to Admission Time

Number of Times	Experimental Group n	%	Comparison Group n	%	Total n
Never	32	18	25	14	57
1 to 3	85	48	102	55	187
4 or More	62	34	56	31	118
Total	179	100	183	100	362

Frequency Missing = 2

Appendix M

Table 1

Respondents' Age in Years

	Experimental Group	Comparison Group
$\bar{X}$	77.0	78.6
S.D.	11.8	9.8
Range	45-101	49-101
Mode	84.0	86.0

Table 2

Respondents' Length of Stay in N.H.

	Experimental Group	Comparison Group
$\bar{X}$	49.3	45.5
S.D.	49.0	42.1
Range	2.0-264.0	1.0-206.0
Mode	24	60